STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152585	A. BUILDING _____ B. WING _____	C 04/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE SHADELAND STATION	**7155 SHADELAND STATION STE 130 INDIANAPOLIS, IN 46256**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS This was an ESRD federal complaint investigation. Complaint #: IN00144637- Unsubstantiated: lack of sufficient evidence. Survey date: April 1, 2014 Facility Number: 003483 Medicaid Number: 200424460 Surveyor: Miriam Bennett, RN, BSN, PHNS Fresenius Medical Care Canal Dialysis is in compliance with the Conditions for Coverage 42 CFR 494.30 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN April 3, 2014	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.